

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116808

6833

## CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with  
 the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. VA.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL BELFOREST HILL</b>		c. LENGTH OF STAY IN 1b <b>11 mos</b>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL DELIVERY</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RESSIE</b>		First <b>PEARL</b>	Middle <b>BLAKE</b>
4. DATE OF DEATH Month <b>JUN</b> Day <b>14</b> Year <b>19 59</b>		5. SEX <b>F</b>	
6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>JAN 9, 1898</b>		9. AGE (In years last birthday) <b>61 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIS CUTLIP</b>		14. MOTHER'S MAIDEN NAME <b>EMMA BROWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address <b>RUTH BROWN, FOREST HILL, Md</b>		18. DUE TO PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA - ORTHOSTATIC PNEUMONIA</b>	
19. INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>		20. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA UTERUS WITH GENERALIZED METASTASES</b>	
21. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
23. MEDICAL CERTIFICATION		24. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
25. TIME OF INJURY Month, Day, Year Hour a. m. <b>—</b> 19 p. m. <b>—</b>		26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		28. (City or town) (County) (State)	
29. I certify that I attended the deceased from <b>JUNE 14, 19 59</b> to <b>JUNE 14, 19 59</b> that I last saw the deceased alive on <b>JUNE 14, 19 59</b> , and that death occurred at <b>11:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Philip W. Henman, M.D., 307 HICKORY</b> DATE SIGNED <b>JUNE 14, 1959</b>			
30. ACTUAL SIGNATURE <b>Philip W. Henman</b>		31. PHYSICIAN'S NAME (Type) <b>PHILIP W. HENMAN, M.D., BEL AIR, Md</b>	
32. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		33. DATE THEREOF <b>June 17, 1959</b>	
34. NAME OF CEMETERY OR CREMATORIAL <b>End of the Trail</b>		35. LOCATION (City, town, or county) <b>St. Pauls, W. Va.</b>	
36. FUNERAL DIRECTOR'S SIGNATURE <b>W.H. Henman</b>		37. ADDRESS <b>Benson, Md.</b>	
38. REC'D BY REGISTRAR DATE <b>JUN 18 '59</b>		39. REGISTRAR'S SIGNATURE <b>Arthur S. Henman</b>	

DEPARTMENT OF DEFENSE - STATE OF HAWAII - FEDERAL BUREAU OF INVESTIGATION

CHIEF OF POLICE

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6834

## CERTIFICATE OF DEATH

116809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Rocks</b>		c. LENGTH OF STAY IN 1b <b>5 Mo S</b>	
d. NAME OF HOSPITAL (If not in hospital, give street, address) OR INSTITUTION <b>ROCKS OF DEER CREEK REST HOME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XRD #1 Box 231 A, BEL AIR</b>	
d. STREET ADDRESS <b>1 Rt 1</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>OSCAR</b>		First <b>OTIS</b>	Middle <b>CLINGENPEEL</b>
4. DATE OF DEATH <b>JUNE 8 1959</b>		Month <b>JUNE</b>	Day <b>8</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>JUNE 13, 1899</b>		9. AGE (In years lost birthday) <b>59 yr.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AIRCRAFT RIVETER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>CHARLES CLINGENPEEL</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W-I 171-05-8298</b>	
17. INFORMANT <b>Lucille R. Orlando</b> Address <b>BEL AIR RD 1 Box 231 A Md</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE</b> DUE TO (c) <b>ACUTE CORONARY THROMBOSIS</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN OVER 7 YRS</b>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL VASCULAR ACCIDENT 1952</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>BEL AIR</b> (County) <b>Md</b> (State) <b>Md</b>	
21. I certify that I attended the deceased from <b>JAN 24, 1959</b> to <b>JUNE 8, 1959</b> , that I last saw the deceased alive on <b>JUNE 8, 1959</b> , and that death occurred at <b>11:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Philip W. Heuman M.D. 907 HICKORY BEL AIR, Md</b> DATE SIGNED <b>JUNE 8, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIA</b>		22b. DATE THEREOF <b>JUNE 11/59</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>BEL AIR MEMORIAL GARDENS</b>		22d. LOCATION (City, town, or county) <b>BEL AIR HARFORD Md</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Foster Bel Air Md</b>		24a. REC'D BY REGISTRAR VS A15 (4) 15M 9/55	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Robert S. Keane</b>	
DATE <b>JUN 10 '59</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 104

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

6818 Items 8,9 FilmG244 7-20-59 et

06810

**CERTIFICATE OF DEATH**

Item 9 FilmG244 6-23-59 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town)	MARYLAND LENGTH OF STAY (In this place)	STATE MD CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY HARFORD (If rural give location)
HARFORD HARFORD TOWN HAVRE DE GRACE 30YRS		24 HARFORD STREET ADDRESS 127 STOKES, ST	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE (Month) (Day) (Year)</b>	
(First) HARRY (Middle) CRESNER (Last)		JUNE 13, 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 1880 JUN 15, 1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY RETIRED	9. AGE last birthday 78 11 78
10c. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM E CRESNER		14. MOTHER'S MAIDEN NAME MARY E TRAGO	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. 216-05-3904	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Mr. MARGARET E CRESNER, MD	
<b>18. MEDICAL CERTIFICATION</b>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
442X IMMEDIATE CAUSE (A) Cardiac Insufficiency			
ANTECEDENT CAUSE(S) DUE TO (B) Cardiac - Renal			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>6-12</u> , 1959, to <u>6-12</u> , 1959, that I last saw the deceased alive on <u>6-12</u> , 1959, and that death occurred at <u>M.</u> from the causes and on the date stated above.			
SIGNATURE <u>R. L. Lewis</u>		ADDRESS (Street, city, town, state) <u>MD - Harford Co. MD</u>	
DATE SIGNED <u>6-13-59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 6-16-1959	
		NAME OF CEMETERY OR CREMATORIUM MT ZION CEM.	
		LOCATION (City, town, or county) HARFORD Co. MD	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Oliver S. Kraus</u>	
DATE JUN 16 '59		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madden</u>	
		ADDRESS <u>Mitchell Harde Grace, MD.</u>	



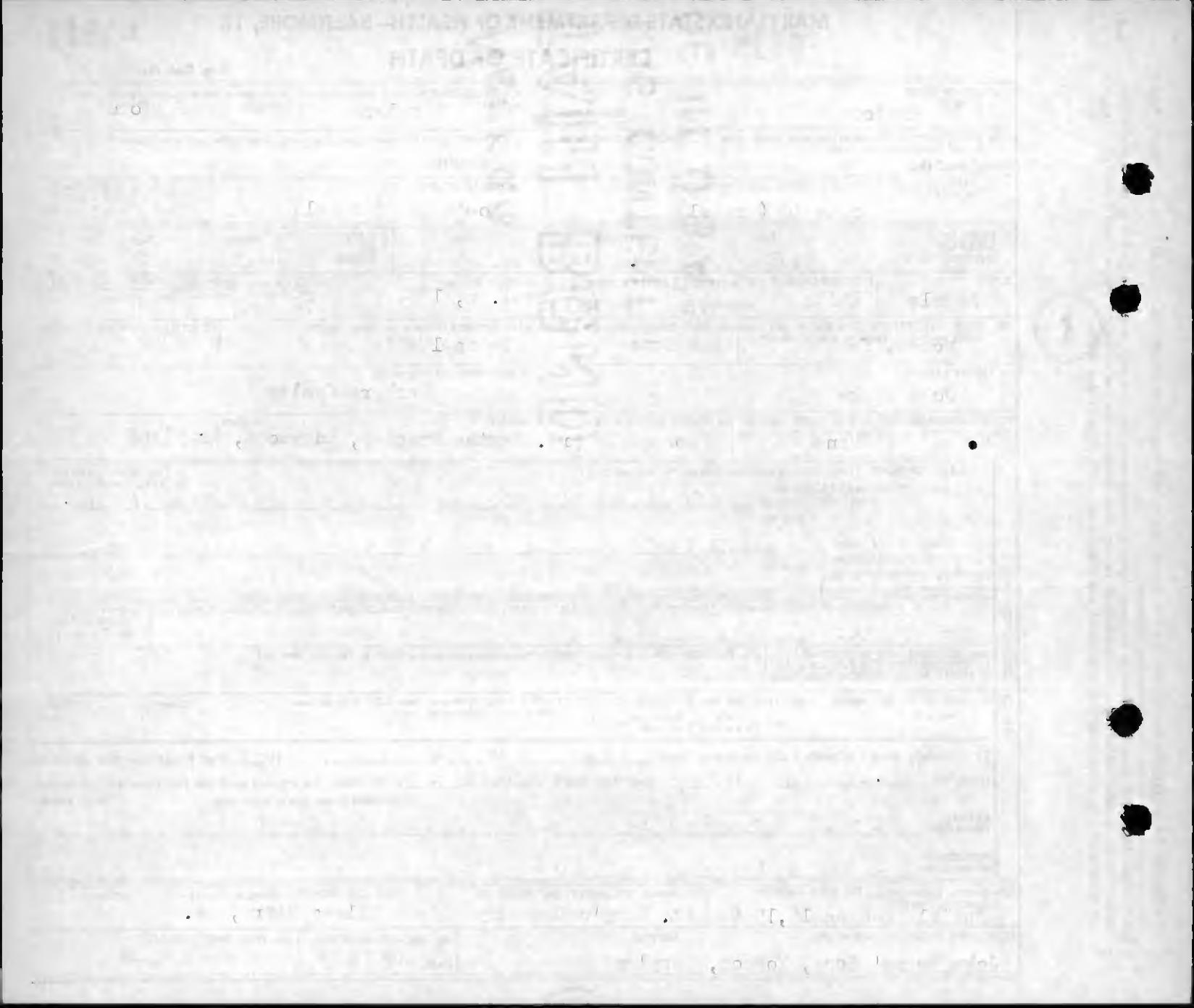
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After item 18, the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6835**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **06811**

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route 40 (rural)</b>			d. STREET ADDRESS <b>Route 40 (rural)</b>		
3. NAME OF DECEASED (Type or print) <b>KATHERINE DELORES CROWE</b>			First	Middle	Last
4. DATE OF DEATH <b>JUNE 12, 1959</b>			Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1882</b>	9. AGE (In years lost birthday) <b>76 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>John Burke</b>		
14. MOTHER'S MAIDEN NAME <b>Barbara Keeley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Regina Frasher, Edgewood, Maryland</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span>					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC AND RENAL DECOMPENSATION</b> 1 YEAR 442X DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> MANY YEARS DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="float: right;">19. WAS AUTOPSY PERFORMED?</span>					
HYPERTROPHIC ARTHRITIS <span style="float: right;">YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></span>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JUNE 11, 1959</b> to <b>JUNE 12, 1959</b> that I last saw the deceased alive on <b>JUNE 11, 1959</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>C. W. Stewart, Jr., M.D.</b> ADDRESS (Street, city or town, state) <b>Box 95, Edgewood, Md.</b> DATE SIGNED <b>6/12/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 15, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Wilkes Barre, Pa.</b>			(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>			24a. REC'D BY REGISTRAR <b>Arthur S. Trahan</b>		
ADDRESS			DATE <b>JUN 16 '59</b>		



6836

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN**: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR**: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 155 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>Harford</b> CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN <b>Forest Hill</b> HOSPITAL OR INSTITUTION OR STREET ADDRESS		STATE <b>MARYLAND</b> LENGTH OF STAY (In this place) <b>50 years</b> STREET ADDRESS	
STATE <b>Maryland</b> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Forest Hill</b>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (First) <b>Abram</b> (Middle) <b>Gorsuch</b> (Last) <b>Ensor</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) <b>June</b> (Day) <b>30</b> (Year) <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>August 11, 1879</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John E. Ensor</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Gorsuch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service) <b>-----</b>		16. SOCIAL SECURITY NO. <b>213-12-4970</b>	
17. INFORMANT & ADDRESS <b>Florence W. Ensor</b>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>450.0</b> IMMEDIATE CAUSE (A) <b>Hypostatic Lobar Pneumonia</b> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <b>Generalized Arteriosclerosis</b> GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Parkinson's Disease; Diabetes Mellitus</b>			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) <b>June</b> (Day) <b>30</b> (Year) <b>19 59</b>		21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>June 30, 19 59</b> , to <b>June 30, 19 59</b> , that I last saw the deceased alive on <b>June 30, 19 59</b> , and that death occurred at <b>12:00AM</b> , from the causes and on the date stated above. SIGNATURE <b>Willard P. Hudson</b> M.D. ADDRESS (Street, city, town, state) <b>Forest Hill, Maryland</b> DATE SIGNED <b>July 1, 1959</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>7/3/1959</b> NAME OF CEMETERY OR CREMATORIAL <b>Rock Spring</b> LOCATION (City, town, or county) <b>Forest Hill, Maryland</b> (State) <b>July 1, 1959</b>	
24. REC'D BY REGISTRAR <b>JUL 6 '59</b>		REGISTRAR'S SIGNATURE <b>Charles L. Bunn</b> 25. FUNERAL DIRECTOR'S SIGNATURE <b>Charles C. Rantz</b> ADDRESS <b>Garrettville, Md.</b>	

STATE OF NEW YORK  
DEPARTMENT OF STATE - CHARTER

CERTIFICATE OF STATE

RECEIVED

RECEIVED BY THE STATE OF NEW YORK

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6819

116813

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Holme de Grace</b>		c. LENGTH OF STAY IN 1b <b>16 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		d. STREET ADDRESS <b>1148 Osborn Rd</b>		
d. NAME OF HOSPITAL (If not a hospital, give street address) OR INSTITUTION <b>Harford Memorial Hosp</b>				d. STREET ADDRESS <b>1148 Osborn Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Betty</b>		First <b>B</b>	Middle <b>C.</b>	Last <b>FARNUM</b>	4. DATE OF DEATH <b>JUNE 27 1959</b>	Month <b>JUNE</b>	Day <b>27</b>	Year <b>1959</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/10/1891</b>	9. AGE (In years last birthday) <b>67 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Broker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canned foods</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James T. CURRY</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Pearce</b>				Address <b>Norfolk, Va.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>213-09-4941</b>		17. INFORMANT <b>James Farnum</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO <b>Abdominal carcinoma toxic</b> (c) <b>adenocarcinoma, R. kidney</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>617 W. Belair</b>		20f. (City or town) <b>Aberdeen</b>	(County) <b>Harford</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>June 5, 1958</b> , to <b>June 27, 1959</b> , that I last saw the deceased alive on <b>June 27, 1959</b> , and that death occurred at <b>5:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>617 W. Belair</b>								
ACTUAL SIGNATURE <b>B. J. Plumkett, Jr.</b>		M.D.				DATE SIGNED <b>6-27-59</b>		
PHYSICIAN'S NAME (Type) <b>B. J. Plumkett, Jr.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-30-1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Freedom Cemetery</b>		22d. LOCATION (City, town, or county) <b>New Freedom, Pa.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Patterson, Jr.</b>		ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clinton &amp; Krause</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6820

06814

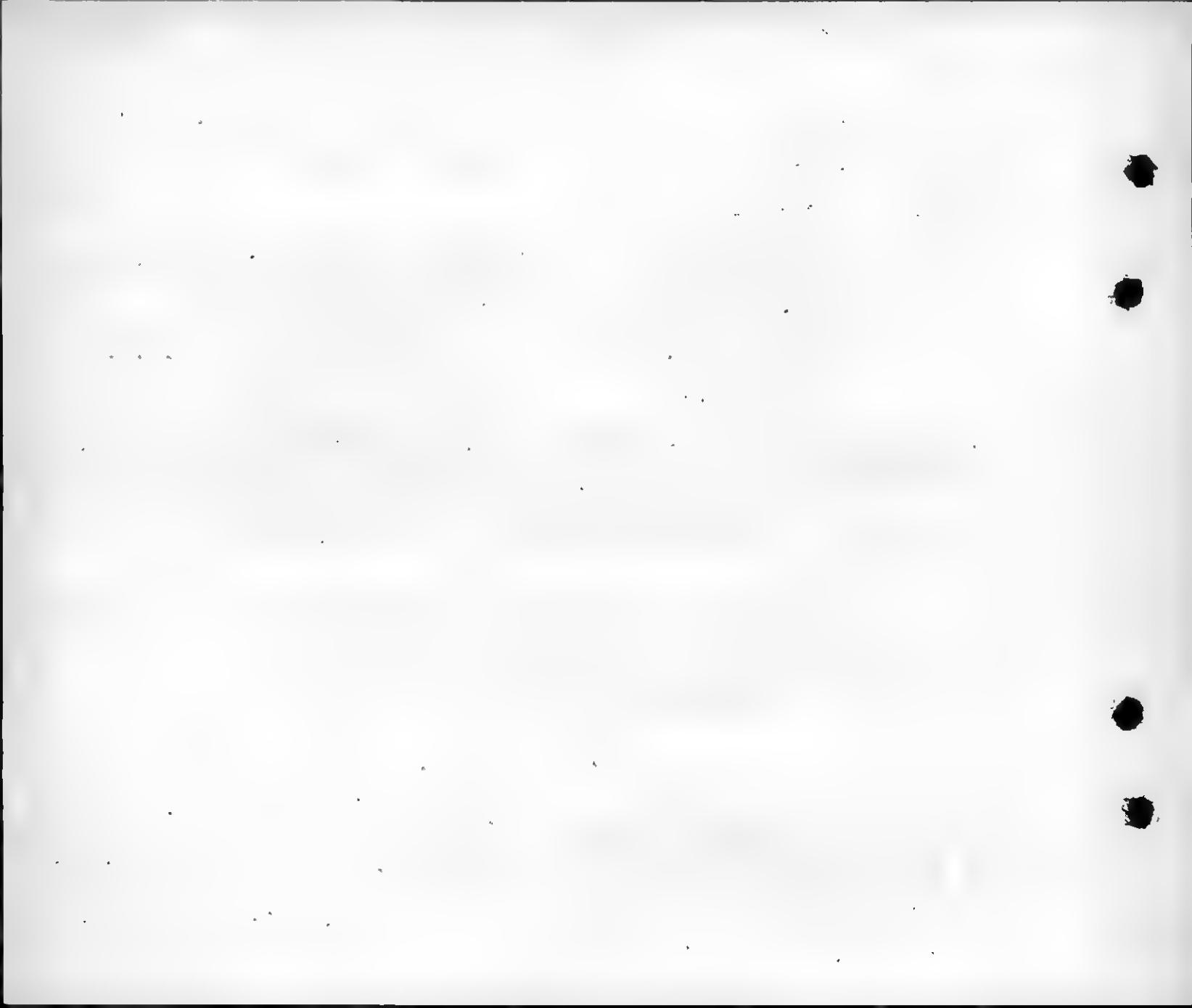
## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Memorial Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Abingdon</b>	
f. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Hugh</b>	Middle	Last <b>Fisher</b>
4. DATE OF DEATH	Month <b>June</b>	Day <b>7,</b>	Year <b>19 59</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1883</b>
9. AGE (In years last birthday) <b>76 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. labor</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fisher</b>		14. MOTHER'S MAIDEN NAME <b>Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>213-20-2497A</b>	INFORMANT <b>Mrs. Mauda Sutt Bel Air, Md.</b>
17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c)	
19. MEDICAL CERTIFICATION		Coronary Thrombosis, Dif. of Left Arteriosclerotic Cardiovascular Disease INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	
20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/6</b> , 19 <b>57</b> , to <b>6/7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>6/7</b> , 19 <b>59</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>E. Louis Kahan</b>		ADDRESS (Street, city or town, state) <b>Box 966 Edgewood, Md. 21215</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/10/1959</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>William Watters</b>		22d. LOCATION (City, town, or county) (State) <b>Gooptown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles C. Kurtz Garrettville Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 11 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Cathleen S. Thomas</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6821

06815

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Our de Grace</i>		b. COUNTY <i>Harford</i>	
c. LENGTH OF STAY IN 1b <i>16 1/2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		d. STREET ADDRESS <i>411 Roberts Way</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Harriet</i>		first <i>H.</i>	Middle <i>Galbreath</i>
4. DATE OF DEATH <i>June 29</i>		Month <i>June</i>	Day <i>29</i>
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>2/28/74</i>		9. AGE (In years by birthday) <i>85 yrs</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	10c. BIRTHPLACE (State or foreign country) <i>Pa.</i>
11. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>James Harris</i>		14. MOTHER'S MOTHER'S MAIDEN NAME <i>Matilda Lytle</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>307-07-7267</i>	17. INFORMANT <i>B. J. Gyers - son-in-law - same</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>left ventricular failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
(b) DUE TO <i>arteriovenous heart disease</i>		>14 mos.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriovenous</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Apr 1</i> , 1958, to <i>June 29</i> , 1959, that I last saw the deceased alive on <i>June 29</i> , 1959, and that death occurred at <i>12 NCPN</i> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>B. J. Plunkett Jr.</i>		ADDRESS (Street, city or town, state) <i>617 W. Belair Ave</i>	
21. I certify that I attended the deceased from <i>Apr 1</i> , 1958, to <i>June 29</i> , 1959, that I last saw the deceased alive on <i>June 29</i> , 1959, and that death occurred at <i>12 NCPN</i> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>B. J. Plunkett Jr.</i>		DATE SIGNED <i>6-29-59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>6/30/59</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Elm Ridge</i>
22d. LOCATION (City, town, or county) <i>Muncie, Indiana</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barry</i>		24a. ADDRESS <i>Tarring Funeral Home</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
24a. REC'D BY REGISTRAR DATE <i>JUL 6 '59</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached from the certificate as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06816

6837

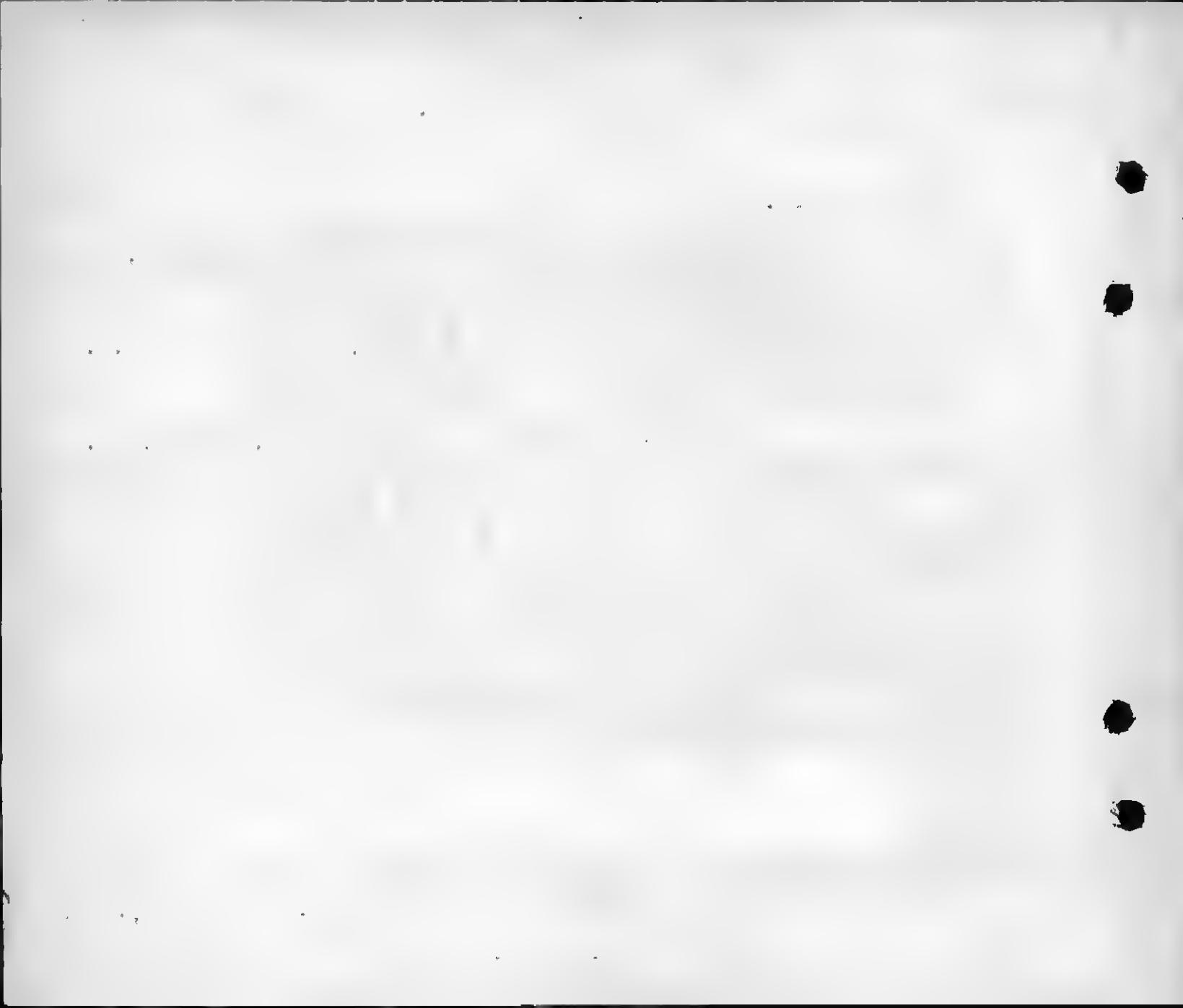
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Harford</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dublin</b>		c. LENGTH OF STAY IN 1b <b>52 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dublin</b>		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Darlington R.D.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <b>RALPH</b>	Middle <b>COAST</b>	Last <b>GALLION</b>	4. DATE OF DEATH	Month <b>June</b>	Day <b>7</b>	Year <b>1959</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Nov. 12, 1906</b>	9. AGE (In years last birthday) <b>52</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Proof technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil service</b>		11. BIRTHPLACE (State or foreign country) <b>Dublin, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George K. Gallion</b>		14. MOTHER'S MAIDEN NAME <b>Sadie Burkins</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-20-7692</b>		17. INFORMANT <b>Mrs. Anna Mae Gallion, Dublin, Md.</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Acute Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH <b>immed</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>May 8, 1947</b> , to <b>June 7, 1959</b> , that I last saw the deceased alive on <b>June 7, 1959</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Dudley Phillip, M.D.</b> PHYSICIAN'S NAME (Type) <b>Darlington R.D.</b>						ADDRESS (Street, city or town, state) <b>Darlington R.D. 6/8/59</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Southern</b>		22d. LOCATION (City, town, or county) (State) <b>Dublin, Harford Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harbins</b>		ADDRESS <b>Delta, Penna.</b>		24a. REC'D BY REGISTRAR <b>JUN 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Critch &amp; Krause</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed in by the funeral director. Page 3 should be detached from this certificate as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10W

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

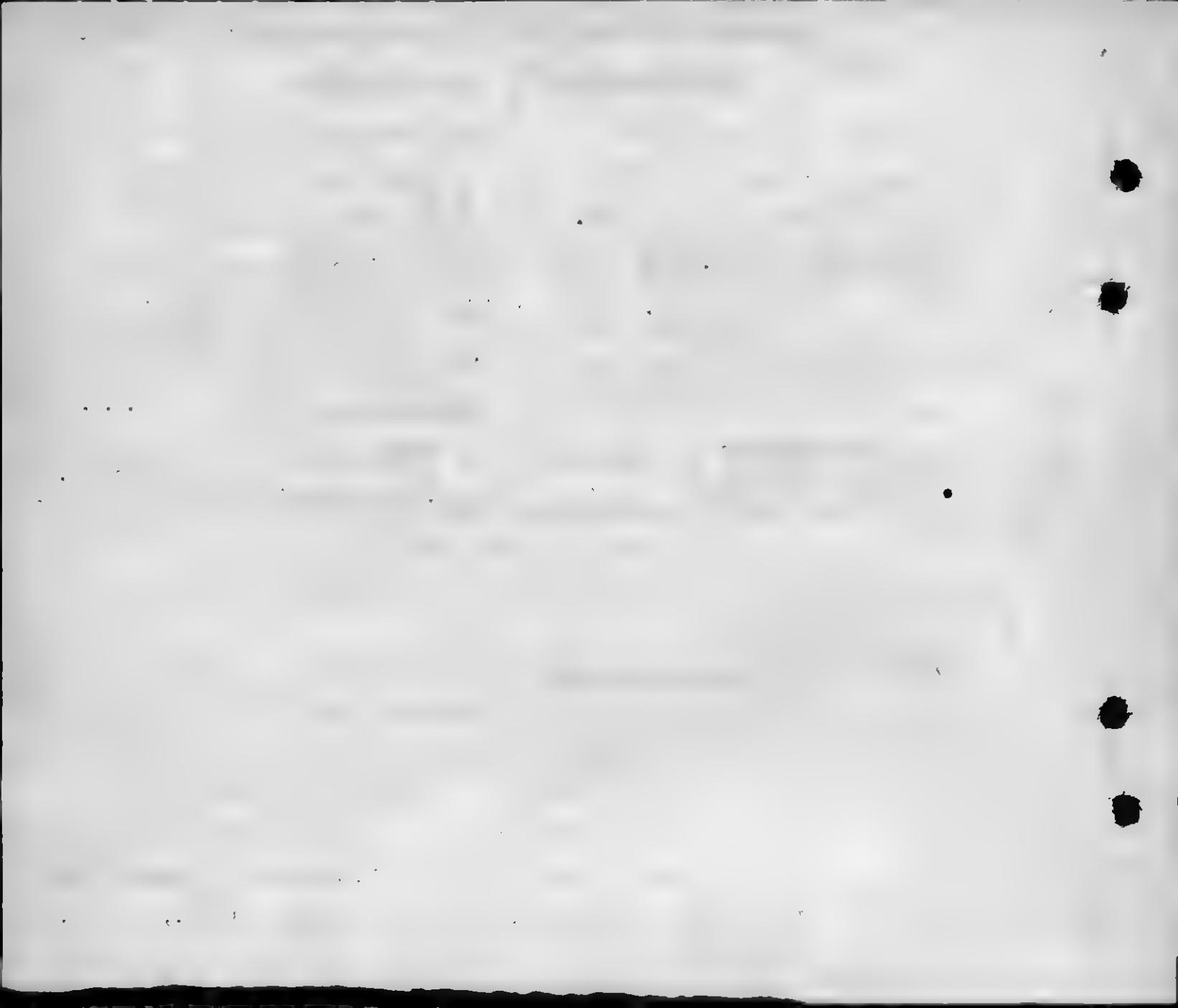
16817

6822

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Harford	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Maryland	COUNTY Harford
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Bel Air	2 Mo.	X STREET ADDRESS	Edgewood	(If rural give location)
Harford Conv. Home			Willoughby Beach		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
(First) Ellen S. Goodrich			(Month) June	(Day) 15	(Year) 19 59
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. IF UNDER 1 YEAR Months Days Hours Min.
Female	White	Widow	March 23, 1879	80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
			Practical Nurse	Maryland	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William Madary			Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
no			?	Edgewood, Md. Mrs. Emory Goodrich, Willoughby Beach,	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
1. IMMEDIATE CAUSE (A) Carcinoma of the Pancreas					
ANTECEDENT CAUSE(S) DUE TO					
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from April 30, 19 59, to June 15, 19 59, that I last saw the deceased alive on June 14, 19 59, and that death occurred at 1:05 P.M. from the causes and on the date stated above. SIGNATURE <i>Howard P. Hudson</i> M.D. ADDRESS (Street, city, town, state) <i>Forest Hill, Maryland</i> DATE SIGNED <i>June 16, 1959</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			DATE THEREOF NAME OF CEMETERY OR CREMATORIAL June 18, 1959 Prospect Hill		
24. REC'D BY REGISTRAR DATE JUN 22 '59			REGISTRAR'S SIGNATURE Albert S. Kline		
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Howard P. Hudson</i> <i>Abingdon Md.</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial/cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18  
 6838 CERTIFICATE OF DEATH

06818

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF		c. LENGTH OF STAY IN 1b 13 YRS.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD.		b. COUNTY HARFORD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) PEARL		First	Middle M.	Last	4. DATE OF DEATH JUNE 28 1959	Month	Day	Year			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-24-1882		9. AGE (in years last birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) HARFORD c.c. MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME FRANK HEAPS		14. MOTHER'S MAIDEN NAME NELLIE FURLOUGH		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO		17. INFORMANT Mrs John Hudson Cardiff, Md.		INTERVAL BETWEEN ONSET AND DEATH 2 years 8 months					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Generalized coronary disease Cardiomegaly of the liver									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>June 21, 1959</u> to <u>June 25, 1959</u> that I last saw the deceased alive on <u>June 21, 1959</u> , and that death occurred at <u>125A</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Benjamin D. C. Cardiff</u> M.D.						ADDRESS (Street, city or town, state) DATE SIGNED 6/24/59					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-1-59		22c. NAME OF CEMETERY OR CREMATORIAL ST. MARY'S		22d. LOCATION (City, town, or county) PYLESVILLE HARFORD Co., MD. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Graham Stewart, Esq.		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
VS A15 (4) 15M 9/55				DATE JUN 30 '59		C. S. Knau					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06819

6823

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL Hosp.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAURE DE GRACE</b>	
3. NAME OF DECEASED (Type or print) <b>Baby</b>		First <b>Joy</b>	Middle <b>KEECH</b>
4. DATE OF DEATH <b>JUNE 5</b>		Month <b>Month</b>	Day <b>Day</b>
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6-3-59</b>		9. AGE (In years lost birthday) yrs. <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Eugene Keech</b>		14. MOTHER'S M AIDEN NAME <b>GENEVA DEAN Atkinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Due to  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)  Due to  (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <b>19<sup>00</sup></b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Neil Tawdry</b> M.D. ADDRESS (Street, city or town, state) <b>Rising Sun, Md</b> DATE SIGNED <b>6/6/59</b>			
22a. BURIAL/CREMATION, REMOVAL (Specify) <b>6-6-59</b>		22b. DATE THEREOF <b>6-6-59</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>HARFORD MEMORIAL HOSPITAL</b>		22d. LOCATION (City, town, or county) <b>Haure de Grace, Md</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey R. S. Gray</b>		ADDRESS <b>Administrator</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



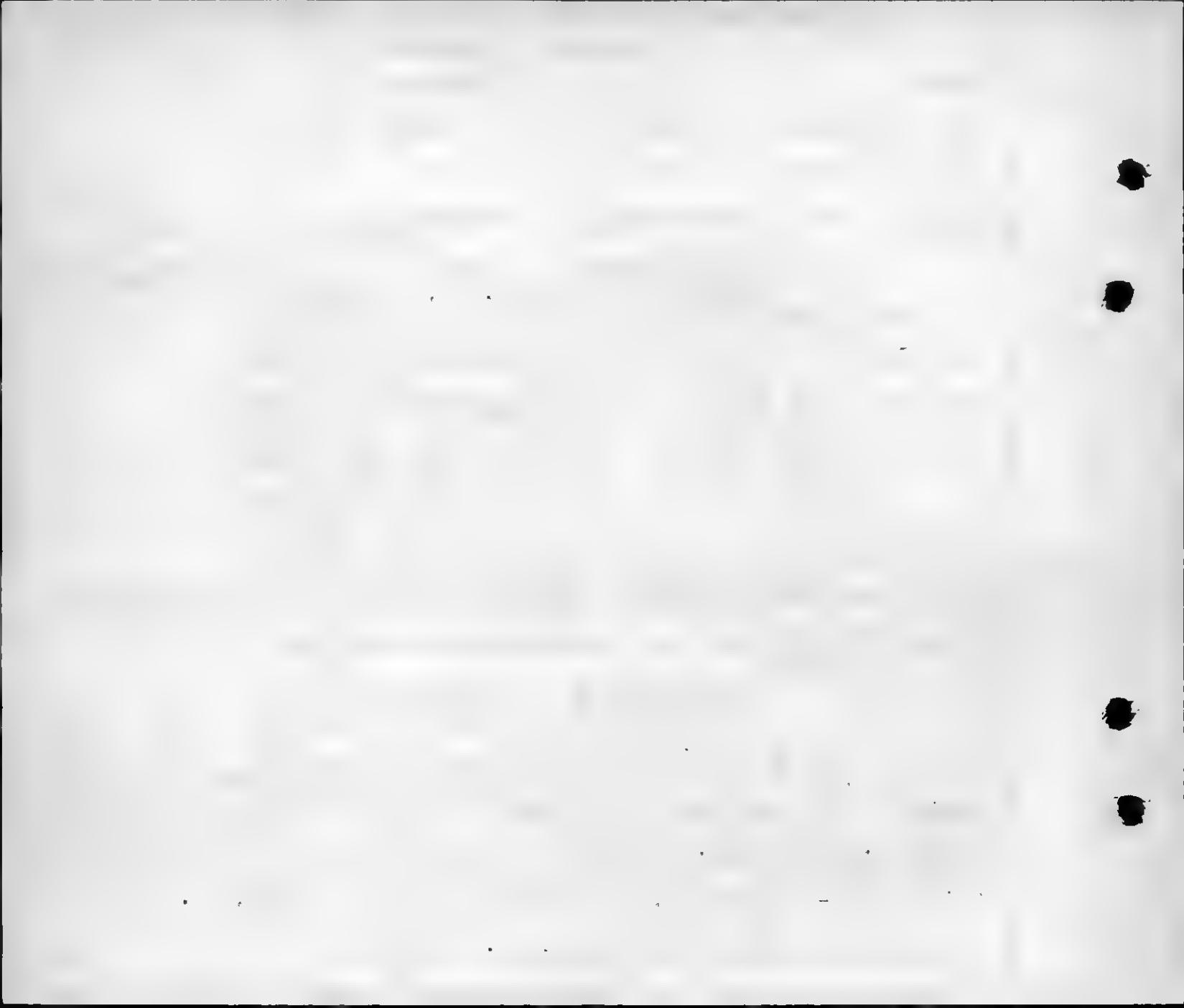
## 6824 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116820

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shore de Grace</i>		c. LENGTH OF STAY IN 1b <i>14 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perryville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hospital</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Charles M. Keesey</i>		First	Middle	Last	4. DATE OF DEATH <i>June 3, 1959</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 10, 1907</i>	9. AGE (In years last birthday) <i>52 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>self employed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Taxi - cab owner</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
13. FATHER'S NAME <i>Charles Keesey</i>		14. MOTHER'S MAIDEN NAME <i>Frances ? Ward</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <i>338-10-4337</i>		17. INFORMANT <i>Clarence I. Benson</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>423.1</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>1</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1, 1959</i> to <i>June 3, 1959</i> that I last saw the deceased alive on <i>July 3, 1959</i> , and that death occurred at <i>Perryville, Md.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Perryville, Md.</i>	
ACTUAL SIGNATURE <i>Clarence I. Benson</i>		DATE SIGNED <i>July 3, 1959</i>			
PHYSICIAN'S NAME (Type) <i>Dr. Clarence I. Benson</i>					
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-6-1959</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St. Marks Cemetery</i>	
22d. LOCATION (City, town, or county) <i>Perryville, Md. Rural</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leila Patterson &amp; Sons</i>		ADDRESS <i>Perryville, Md.</i>		24a. REC'D BY REGISTRAR DATE JUN 8 '59	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6839

## CERTIFICATE OF DEATH

06821

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Fallston</b>		b. COUNTY <b>Harford</b>	
c. LENGTH OF STAY IN 1b <b>16 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Fallston</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pleasantville Road</b>		d. STREET ADDRESS <b>Pleasantville Road</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert Joseph Kennedy</b>		First <b>Robert</b>	Middle <b>Joseph</b>
4. DATE OF DEATH <b>June 1, 1959</b>		Last <b>Kennedy</b>	Month Day Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <b>Nov. 23, 1876</b>		9. AGE (in years lost birthday) <b>82 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done; 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) <b>Retired Farmer</b>		11. BIRTHPLACE (State or foreign country) <b>Rutledge, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph Kennedy</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Norman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mrs. Robert Wagner Fallston, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		<b>Cardiac disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Carcinoma of Stomach 2 yrs</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Walter M. Hammitt</b>		ADDRESS (Street, city or town, state) <b>Baldwin, Md.</b> DATE SIGNED <b>June 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/3/1959</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Johns</b>		22d. LOCATION (City, town, or county) (State) <b>Hydes Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles C. Kurtz</b>		ADDRESS <b>Jarrettsville, Md.</b>	
24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



1521

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be filed with the registrar within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

WES A15C 1-EE 10M

## **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

Item 2, Film G244, 6/19/59 fcw

**CERTIFICATE OF DEATH**

116823

**Reg. Dist. No.**.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Harford</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Bel Air - Rural</b>		MARYLAND LENGTH OF STAY (in this place) <b>4 yrs.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS  <b>Walter's CONVALESCENT Home</b>		STATE <b>Maryland</b> COUNTY <b>Harford</b> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Bel Air - Rural</b> Forest Hill STREET ADDRESS <b>Walter's CONVALESCENT Home</b>	
3. NAME OF DECEASED (Type or Print)  <b>Lo Hie</b>		4. DATE (Month) (Day) (Year) <b>DEATH JUNE 11, 1959</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>		8. DATE OF BIRTH <b>JUNE 21, 1876</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeper</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME  <b>Henry</b>		14. MOTHER'S MAIDEN NAME  <b>Mary Jane BUNCE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>NO</b>		16. SOCIAL SECURITY NO. <hr/>	
17. INFORMANT & ADDRESS <b>Walter's CONVALESCENT Home Records</b>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <b>Coronary Thrombosis</b> ANTECEDENT CAUSE(S) DUE TO (B) <b>Chr. cardio-vascular disease</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) 30 min.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		10 yrs	
19a. DATE OF OPERATION <hr/>		19b. MAJOR FINDINGS OF OPERATION <hr/>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Jan. 1949</b> , 19....., to <b>June 11</b> , 1959....., that I last saw the deceased alive on <b>June 3</b> , 1959....., and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above. SIGNATURE <b>Willard P. Hudson, M.D.</b> ADDRESS <b>(Street, city, town, state)</b> DATE SIGNED <b>6-12-59</b> <b>Forest Hill</b> <b>Maryland</b> <b>(State)</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>JUNE 14, 1959</b>	
24. REC'D BY REGISTRAR <hr/> DATE <b>JUN 15 '59</b>		NAME OF CEMETERY OR CREMATORIAL <b>Rock Spring Church Cemetery</b>	
REGISTRAR'S SIGNATURE <b>Carrie S. Kraus</b>		LOCATION (City, town, or county) <b>Forest Hill, Harford Co., Md.</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <hr/> <b>Joseph W. Foster</b>		ADDRESS <b>W. Broadway &amp; Williams St., Bel Air, Maryland</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a Burial-Transit Permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

6825 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

106824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
Hagerstown Maryland		a. STATE Virginia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY #	
Hagerstown de Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
DGA Hagerstown Memorial Hospital		Cedar Bluff	
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Samuel David Lawson		Lost	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
M		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 5-11-32
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Laborer		Factory Auto	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
West Virginia		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Virgil R. Lawson		Fannie Blackwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
Yes Korea		232-52-8002	
17. INFORMANT		Address	
Father of Cedar Bluff, Va. Box 12A P.O. #1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			
823 X		Compound fracture skull	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.			
(b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARy <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 2 6-10 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat. while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, off ce, bldg., etc.) Perryman Road		20f. (City or town) Perryman (County) Harford (State) Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>Beltair, Md</i>	
ACTUAL SIGNATURE <i>Ronald C Palmer</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer MD</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6/12/1959	
22c. NAME OF CEMETERY OR CREMATORIAL MOUNTAIN VIEW		22d. LOCATION (City, town, or county) Abingdon (State) Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Barron</i>		ADDRESS <i>Aberdeen, Md.</i>	
24a. REC'D BY REGISTRAR JUN 13 1959		24b. REGISTRAR'S SIGNATURE <i>Arline S. Kline</i>	
DATE			



## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for us as a burial transit permit.

VS ABC 155-10A

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

116825

## 6840 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED						
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN)	HARFORD	MARYLAND LENGTH OF STAY (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Md	COUNTY HARFORD				
HOSPITAL OR INSTITUTION OR STREET ADDRESS	JOPPA	14 YRS X	STREET ADDRESS	JOPPA	(If rural give location)				
3. NAME OF DECEASED (Type or Print)			(First)	(Middle)	(Last)				
SARAH				MARBURG					
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	4. DATE (Month) OF DEATH JUNE 2	(Day) 19 59	(Year)		
F	W	SINGLE	FEB 28,	64	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
SALES WOMAN			SAME	MARYLAND			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME						
ABRAHAM MARBURG			MARY BRUSH						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.			17. INFORMANT & ADDRESS			
No						Winnie MARBURG - SAME			
18. MEDICAL CERTIFICATION									
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH									
IMMEDIATE CAUSE (A) ACUTE CORONARY THROMBOSIS									
ANTECEDENT CAUSE(S) DUE TO									
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO									
HYPER TENSION WITH									
(C) CARDIAC INSUFFICIENCY									
INTERVAL BETWEEN ONSET AND DEATH									
INSTANT									
OVER 5 yrs									
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.									
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. INJURY OCCURRED M. White <input type="checkbox"/> Not white <input type="checkbox"/> el work <input type="checkbox"/> el work <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEB 28, 1957, to JUNE 2, 1959, that I last saw the deceased alive on MAY 4, 1957, and that death occurred at 8:00 AM, from the causes and on the date stated above.									
SIGNATURE Philip W. Neuman M.D. 307 Hickory Bel Air, Md JUNE 3, 1959									
ADDRESS (Street, city, town, or county)									
DATE SIGNED									
23. BURIAL, CREMATION REMOVAL (SPECIFY) Burial			DATE THEREOF 8-4-59			NAME OF CEMETERY OR CREMATORY United Hebrew			
24. REC'D BY REGISTRAR			REGISTRAR'S SIGNATURE Clyde S. Kline			25. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis Jr. 2100 Eastern Pl.			
DATE JUN 3 '59									



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6826

116826

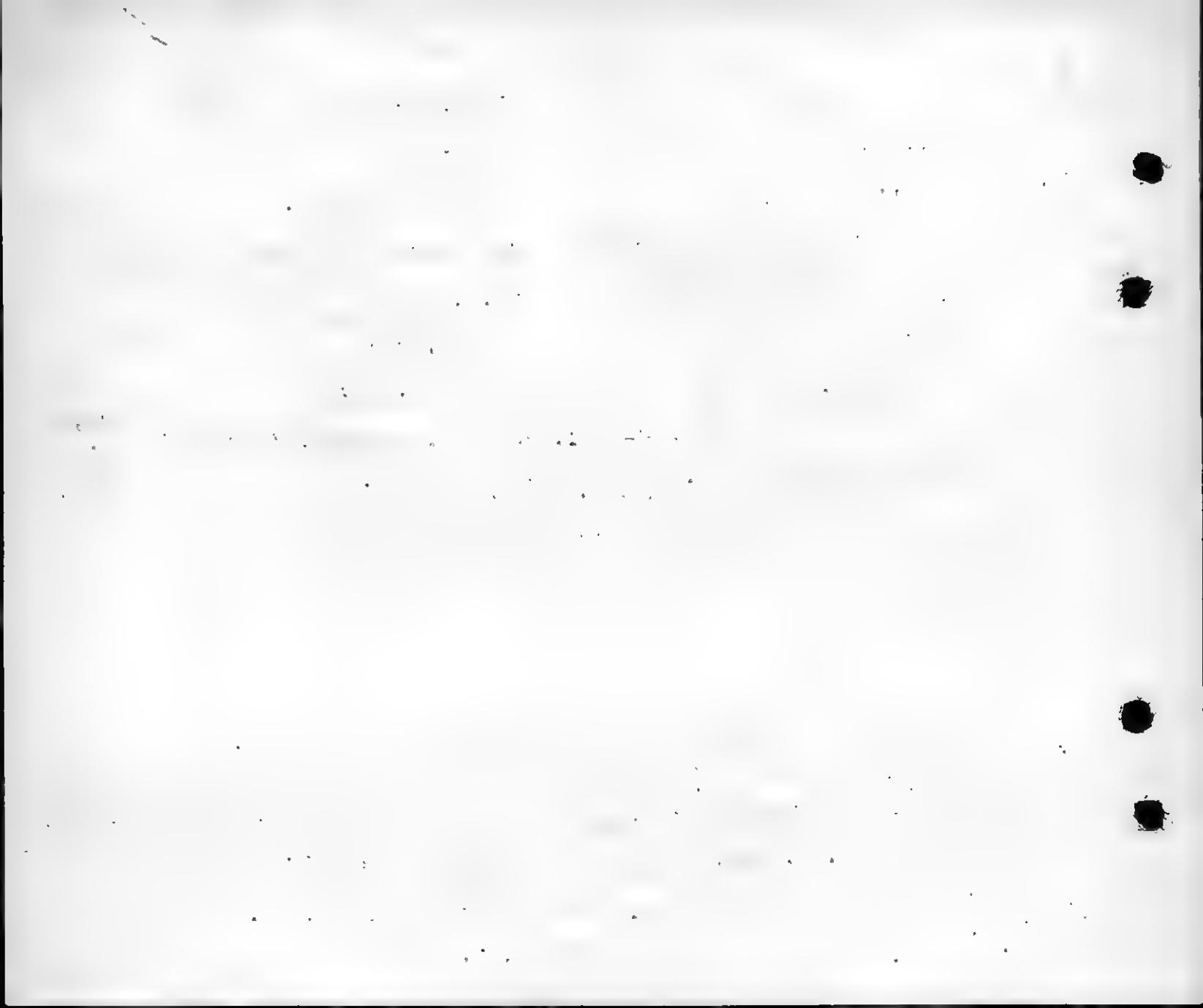
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Pennsylvania</b>		b. COUNTY <b>York</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre De Grace</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>York</b>		d. STREET ADDRESS <b>57 Franklin St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dr. S's Office</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>George Martin</b>		First	Middle	Last	4. DATE OF DEATH <b>June 28 1959</b>	Month	Day	Year
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 4, 1900</b>	9. AGE (in years last birthday) <b>58</b> yrs	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during last 5 years of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John T. Mc Clune</b>		14. MOTHER'S MAIDEN NAME <b>May L. Owens</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>175-10-6964</b>		INFORMANT <b>Hester R. Mc Clune, 57 Franklin St.</b>		Address <b>York, Pa</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO DUE TO (c)		Coronary Thrombosis Arteriosclerotic Cardiovascular Disease?				INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Edw. C. Loo, MD</b>		20f. (City or town) <b>Harford, Md.</b>		(County) <b>Harford Co., Md.</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>June 28th 1959</b> to <b>June 28 1959</b> that I lost sight of the deceased alive on <b>June 28th 1959</b> , one that death occurred at <b>6 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Edw. C. Loo, MD</b>						ADDRESS (Street, city or town, state) <b>211 N. Union Ave., Havre de Grace, Md.</b>		DATE SIGNED <b>6/29/59</b>
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-7-2-1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Rose Cemetery</b>		22d. LOCATION (City, town, or county) <b>York, Pa.</b>		(State) <b>Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leesa Patterson &amp; Sons</b>		ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraut</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 2  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, it may be retained by the hospital or funeral home.  
 page 3 should be detached for use as the burial-transit permit. Then place in more carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Coroner of Harford County **Dr. J. Palmer** has been notified.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6841

## CERTIFICATE OF DEATH

116827

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Magnolia</b>		c. LENGTH OF STAY IN 1b <b>lifetime</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Magnolia</b>	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carrie</b>		First <b>E.</b>	Middle <b>Mc Kinney</b>
4. DATE OF DEATH <b>June, 30 1959</b>	Month <b>Month</b>	Day <b>Day</b>	Year <b>Year</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 13, 1888</b>
9. AGE (In years last birthday) <b>71 yrs</b>	10. IF UNDER 1 YEAR <b>Months</b>	11. IF UNDER 24 HRS. <b>Days</b>	12. IF UNDER 24 HRS. <b>Hours</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Magnolia, Md.,</b>	
11. BIRTHPLACE (State or foreign country) <b>Magnolia, Md.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>	
13. FATHER'S NAME <b>Benjamin Bowen</b>		14. MOTHER'S MAIDEN NAME <b>Susan Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mosby Mc Kinney</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b>	
DUE TO <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>WORKING</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>hypertension</b>		DUE TO <b>ARTERIOSCLEROSIS</b>	
DUE TO <b>CARDIOVASCULAR</b>		DUE TO <b>DISEASE</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>DEC</b> , 1952, to <b>6/30</b> , 1957, that I last saw the deceased alive on <b>5/27</b> , 1959, and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Box 95</b>			
ACTUAL SIGNATURE <b>Benjamin Bowen</b>		DATE SIGNED <b>7/2/59</b>	
PHYSICIAN'S NAME (Type) <b>C. W. STEWART, Jr., M.D.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>July, 3, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cokesbury</b>	
22d. LOCATION (City, town, or county) <b>Abingdon, Harford, Maryland.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Seward &amp; McElroy, Jr.</b>		24a. REC'D BY REGISTRAR DATE JUL 7 '59	
ADDRESS <b>Abingdon, Maryland.</b>		24b. REGISTRAR'S SIGNATURE <b>Carroll S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from  
page 3 should be detached from page 3 and given to the funeral director. Then please remove carbon paper from page 1 and 2 should be retained with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6827

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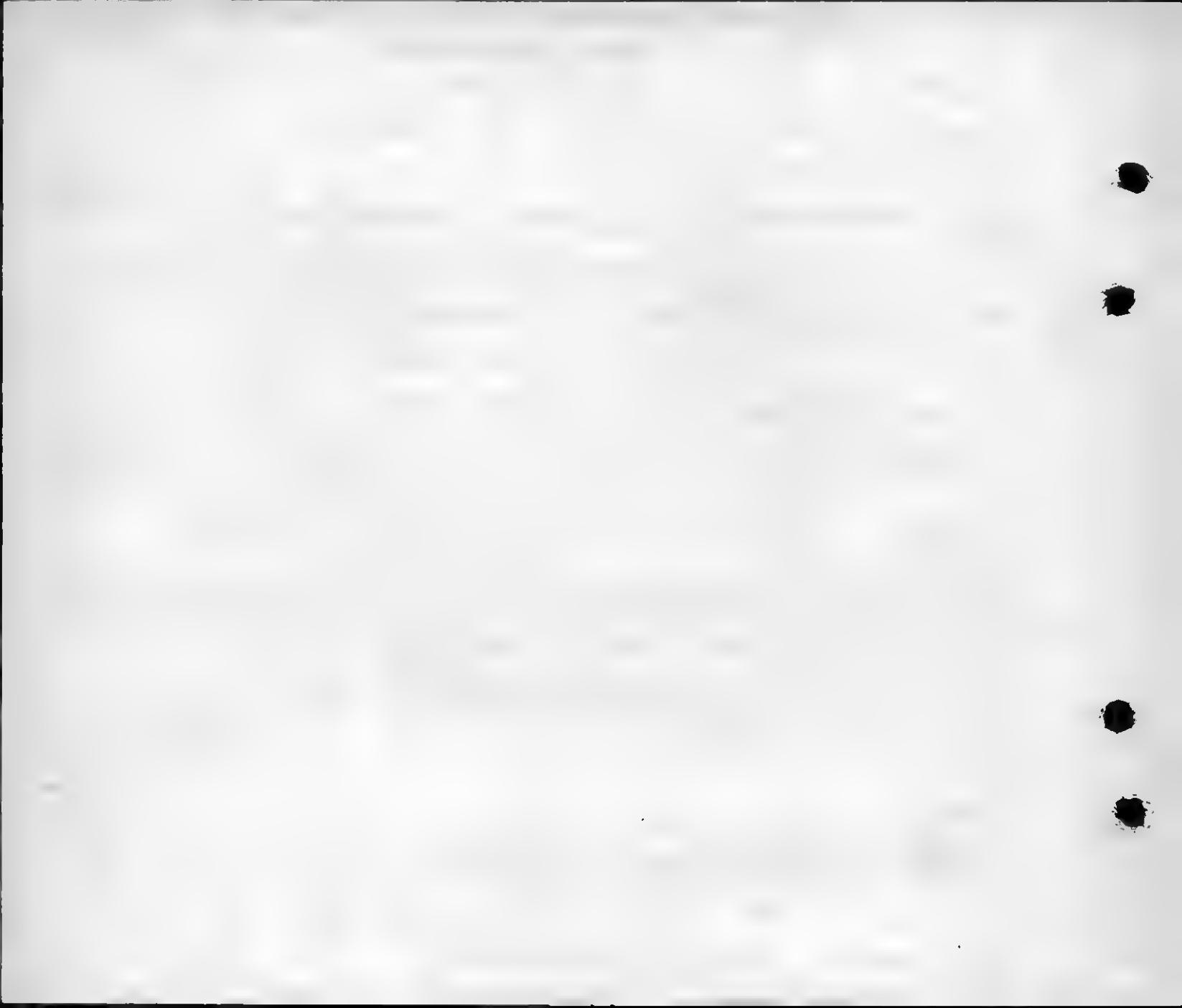
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Harford		a. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace		b. COUNTY Harford	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Harre-de-Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) Or INSTITUTION Harford Memorial Hospital		d. STREET ADDRESS 353 LaFayette ST	
3. NAME OF DECEASED (Type or print) G. Nelson		First	Middle
		Last	DATE OF DEATH
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH MAR. 3, 1912		9. AGE (in years last birthday) 41 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAULING		10b. KIND OF BUSINESS OR INDUSTRY Storage Moving	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George N. Mitchell Sr.		14. MOTHER'S MAIDEN NAME Sarah Evelyn Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Lena J. Mitchell - Havre de Grace MD.		Address 353 LaFayette ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Cerebral Hemorrhage Cardiovascular disease	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 14</u> , 1959, to <u>June 13</u> , 1959, that I last saw the deceased alive on <u>June 13</u> , 1959, and that death occurred on <u>June 13</u> , 1959, M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Carl Lewis</u> ADDRESS (Street, city or town, state) MD. DATE SIGNED <u>6/19</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-17-1959	
22c. NAME OF CEMETERY OR CREMATORIUM ANGEL HILL CEM.		22d. LOCATION (City, town, or county) Havre de Grace MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell Havre de Grace, MD.		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
ADDRESS		24b. REGISTRAR'S SIGNATURE Elaine L. Maura	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

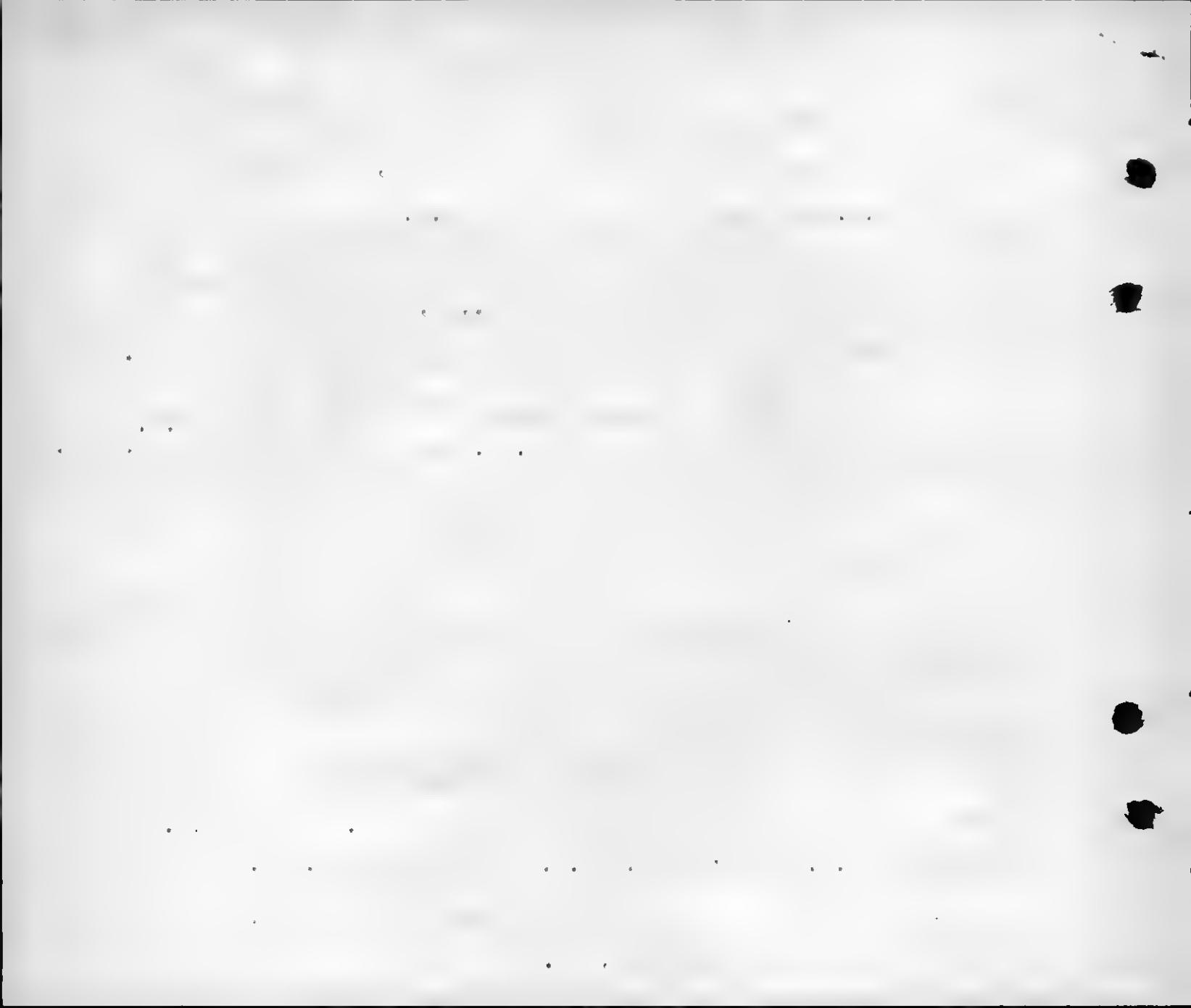
116829

6842

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution residence before admission) a. STATE Maryland		b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D. #3		d. STREET ADDRESS R.D. #3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) MARY		First	Middle	Last	4. DATE OF DEATH June 29 1959	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept., 3, 1861	9. AGE (In years last birthday) 97 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA.		
13. FATHER'S NAME Thomas Carroll			14. MOTHER'S MAIDEN NAME Mary Allen					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. ** **		17. INFORMANT Mrs. R. Leslie Hughes		Address R.D. #3 Aberdeen, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 1 week		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Secondary arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from 5-3, 1957, to 6-29, 1957, that I last saw the deceased alive on 6-29, 1957, and that death occurred at 12:20 pm from the causes and on the date stated above. ADDRESS (Street, city or town, state) B.J. Plunkett, Jr. M.D. 617 W. Bel Air Ave. DATE SIGNED								
ACTUAL SIGNATURE		B.J. Plunkett, Jr. M.D.						
PHYSICIAN'S NAME (Type)		Aberdeen, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/2/59	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Spesutia Cemetery			22d. LOCATION (City, town, or county) Perryman,	(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Farney		Tarring Funeral Home Aberdeen, Md.			24a. REC'D BY REGISTRAR DATE JUL 6 '59	24b. REGISTRAR'S SIGNATURE C. Lewis & Trahan		



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, *i.e.*, within 48 hours "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be handed to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6828 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06830

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission)	
Harford		a. STATE MD b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Harde Grace		Harde Grace	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
Harde Grace		637 - N. Stokes St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM?	
1. 5 Stokes St		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle		Month Day Year	
Edna Etts Pierce		June 25 1959	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/31/1923	
9. AGE (In years, months, and days) 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House Wife		Harde Grace, Md. U.S.A.	
13. FATHER'S NAME George Mouldale		14. MOTHER'S MAIDEN NAME Pearl Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Addressee		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to strangulation DUE TO 974X Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. Hanged self = lamp cord		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 am 6-25 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, 120 ft. (City or town) factory, street, office bldg., etc.) Home		(County) Harde Grace, Md. (State) Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C Palmer		DATE SIGNED 6-25-59	
EXAMINER'S NAME (Type) G. C. Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURN OR CREMATION REMOVAL (Specify) 6/28/59		22b. DATE THEREOF 6/28/59	
22c. NAME OF CEMETERY OR CREMATORIAL Angel Bell		22d. LOCATION (City, town, or county) Harde Grace, Md. (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS, PHONE NUMBER		24a. REC'D BY REGISTRAR, DATE JUN 30 '59	
Puryear, Inc., Harde Grace, Md.		24b. REGISTRAR'S SIGNATURE Arthur & Anna	

VS. A15ME  
SM 2/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06831

6829

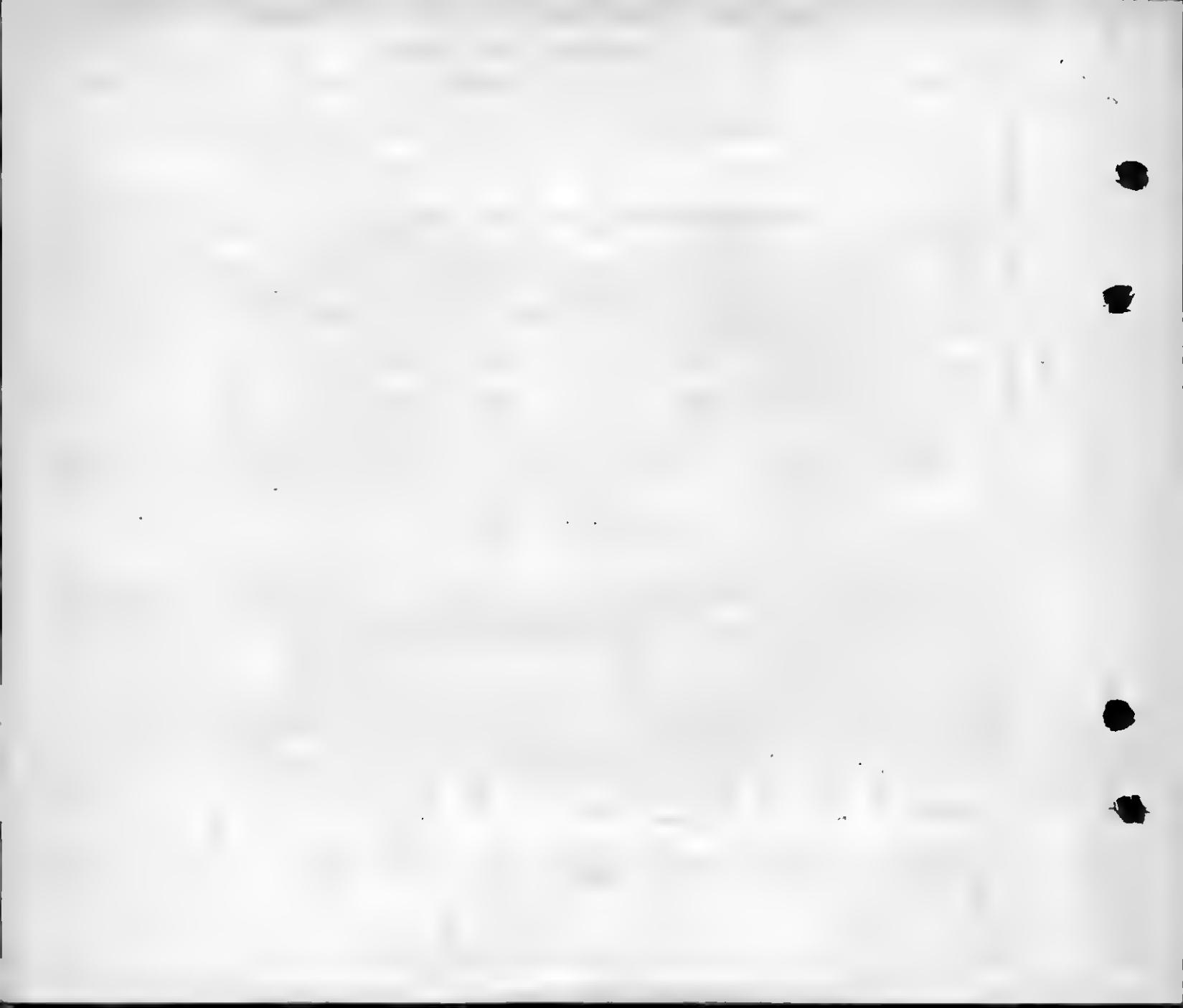
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Harford		Harde-Brace		2 days.		Md.		Aberdeen					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
Harford Memorial Hospital		2 days.		RD # 1									
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	6. DATE OF DEATH	Month	Day	Year					
William Russell Schofield					10	6	6	1959					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday) 67 yrs.					
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		7/10/1891		IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?							
Retired.		Papenter		Md.		USA							
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> 16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
Isaac Henry Schofield		Carrie Schofield, Russell		No		216-10-3804		William J. Schofield.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO		Perforated Gastric Ulcer		INTERVAL BETWEEN ONSET AND DEATH 2 hr.					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b)		DUE TO		Gastric Ulcer		2 mo.					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M., from the causes and on the date stated above. ADDRESS (Street, city or town, state)		22. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)					
ACTUAL SIGNATURE		Peter P. Rodman		6/10/1959		Spesuta Cemetery		Perryman, Md.					
PHYSICIAN'S NAME (Type)		23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 10 '59		24b. REGISTRAR'S SIGNATURE C. 1959					
John G. Barrig		Aberdeen, Maryland											

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6830 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY **Harford**  
 CITY (If outside corporate limits, write RURAL  
 OR and give nearest town)  
 TOWN **Bel Air**

MARYLAND

LENGTH OF STAY  
(in this place)

2 months

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS**Harford Convalescent Home**

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE **Maryland** COUNTY **Cecil**CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN**Port Deposit**STREET  
ADDRESS

(If rural give location)

3. NAME OF  
DECEASED  
(Type or Print)**Elizabeth**

(First) (Middle) (Last)

**Smithson**5. SEX  
Female6. COLOR OR  
RACE  
**White**7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)  
**Single**

8. DATE OF BIRTH

**June 7 1861**4. DATE (Month) (Day) (Year)  
OF DEATH **June 8 1959**

9. AGE last birthday

**98**

yrs.

10. IF UNDER 1 YEAR  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired) **Matron**10b. KIND OF BUSINESS  
OR INDUSTRY  
**College**

11. BIRTHPLACE (State or foreign country)

**Md**12. CITIZEN OF WHAT  
COUNTRY?  
**U.S.A.**

13. FATHER'S NAME

**Nathaniel Smithson**

14. MOTHER'S MAIDEN NAME

**Elizabeth Miller**15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) **No** (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

**Grace C. Tome**

## 18. MEDICAL CERTIFICATION

18a. IMMEDIATE CAUSE **(A) Coronary Occlusion,**INTERVAL BETWEEN  
ONSET AND DEATH  
**3 days**

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, **(B) Chr. Cardio-vascular disease**

?

GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

18b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year)

(Hour)

21e. INJURY OCCURRED

M. While at work  Not while at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 12, 1959**, to **June 8, 1959**, that I last saw the deceased  
alive on **June 8, 1959**, and that death occurred at **10:00A.M.** from the causes and on the date stated above.SIGNATURE **Willard P. Hudson** ADDRESS (Street, city, town, state)DATE SIGNED **June 9, 1959**23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)  
**Burial**

DATE THEREOF

**6-12-1959**

NAME OF CEMETERY OR CREMATORI

**West Nottingham Cem.**

LOCATION (City, town, or county)

**Colora, Md.**

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

**Albert S. Krause**

25. FUNERAL DIRECTOR'S SIGNATURE

**Keva Patterson** ADDRESS **Berryville, Md.**



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116833

6831

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
HARFORD MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
HAURE de Grace		9 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
HARFORD Memorial Hospital		70. 2	
3. NAME OF DECEASED (Type or print)		First	Middle
Leona S.		Last	
4. DATE OF DEATH		Month	Day
Temple		JUN	13
5. SEX		6. COLOR OR RACE	
Female		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input checked="" type="checkbox"/>		JUNE 1, 1874	
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
85			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
House wife		HOME	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Md.		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
UNK.		UNK.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or date of service)		—	
17. INFORMANT		Address	
Mrs. Willard ANDERSON HAVRE DE GRACE, MD.		R.R. 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Infarction of intestine due to malignant thrombosis	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on <u>July 13, 1959</u> , and that death occurred at <u>8:15 AM</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <i>R. McLean Mitchell</i>		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-15-1959	
22c. NAME OF CEMETERY OR CREMATORIAL ROCKRUN CEM.		22d. LOCATION (City, town, or county) HARFORD Co., MD	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. McLean Mitchell</i>		ADDRESS HAURE DE GRACE, MD	
		24a. REC'D BY REGISTRAR DATE JUN 16 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached from the burial-transit permit. Then, please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## INSTRUCTIONS

TO ATTENDING PHYSICIAN HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

116834

## 6843 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		MARYLAND		STATE		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN		10 days		X		FORST HILL	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				(If rural give location)			
Harford Co Hosp							
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
Rey W Tyson				JAN 23 1959			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
M	White	SINGLE	Feb 17-1892	67	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
FARM LABOR				Churchville Md			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James W Tyson				Elizabeth Murphy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		✓		Alfred Tyson 106 B1/1 S Belair Md			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Arteriosclerotic CV disease							
IMMEDIATE CAUSE (A)							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1, 1959, to Jan 23, 1959, that I last saw the deceased alive on Jan 21, 1959, and that death occurred at 1 P.M., from the causes and on the date stated above. SIGNATURE							
ADDRESS (Street, city, town, state)							
DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIUM		LOCATION (City, town, or county) (State)	
Burial		June 25/59		Angus Hill Cemetery		Harford Grace Harford Md	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
Clyde & Kline				Joseph T. Bots Belair Md			
DATE JUN 29 59							

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

116835

6832

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hawthorne Grace</i>		c. LENGTH OF STAY (IN 1b) <i>1/2 hour</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>Wolf</i>	Last <i>Kill</i>		
4. SEX <i>Male</i>	5. COLOR OR RACE <i>White</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>June 20, 1938</i>		
8. AGE (In years last birthday) yrs. <i>21</i>	9. IF UNDER 1 YEAR Months <i>0</i>	10. IF UNDER 24 HRS. Days <i>0</i>	11. Month <i>June</i>		
12. Day <i>20</i>	13. Year <i>1959</i>	14. BIRTHPLACE (State or foreign country) <i>Harford Co., MD</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>754-54-1234</i>	17. INFORMANT <i>Me</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGENITAL HEART DEFORMITY</i> DUE TO <i>754.5</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. p. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Baltimore</i>	(County) <i>MD</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>6/20/59</i> , 19 <i>59</i> , to <i>6/20/59</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>6/20/59</i> , 19 <i>59</i> , and that death occurred at <i>MD</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>ADDRESS</i> DATE SIGNED <i>6/20/59</i>					
ACTUAL SIGNATURE <i>R.B. Noyment</i>	PHYSICIAN'S NAME (Type) <i>R.B. Noyment</i>		M.D.		
22a. BURIAL, Cremation REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>June 21, 1959</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Harlington</i>	22d. LOCATION (City, town, or county) <i>Harford Co., MD</i>	(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>eff &amp; Bailey</i>	24a. ADDRESS <i>Harlington</i>	24b. REC'D BY REGISTRAR DATE <i>JUN 25 '59</i>	24c. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from the certificate as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

